MISSOURI DEPARTMENT OF HEALTH
BUREAU OF FAMILY HEALTH

CONSENT-AUTHORIZATION FOR EXAMINATION, COLLECTION OF EVIDENCE AND RELEASE OF INFORMATION

FORM 1

PLEASE TYPE OR PRINT

NAME OF VICTIM	
NAME OF PHYSICIAN	ADDRESS OF PHYSICIAN
NAME OF HOSPITAL OR OTHER FACILITY	ADDRESS OF HOSPITAL OR OTHER FACILITY
NAME OF COUNTY WHERE INCIDENT OCCURRED	

I hereby consent and authorize the physician named above and the agents of said physician to conduct an initial forensic medical examination and to deliver a report of the examination to the Prosecuting Attorney of the county named above so that the cost of the examination can be borne by the state. I further understand that hospitals and physicians are required to notify the Division of Family Services of known or suspected child abuse and that, if child abuse is found or suspected, this form and other reports and evidence may be released to the Division of Family Services and law enforcement. **(For follow-up tests to determine if you have contracted a sexually transmitted disease and another pregnancy test, please call your local county health department to see if they offer these tests and services and if they are free.)**

NAME OF PARENT OR GUARDIAN

ADDRESS

I understand that if I am less than 18 years of my age, my parent or guardian (named above) will be notified that this forensic medical examination has taken place.

I hereby state that to the best of my knowledge, I have no insurance nor am I on Medicaid or Medicare, or other third party insurance that would cover the cost of this forensic medical examination.

SIGNATURE OF VICTIM ►	DATE
ADDRESS	